

tures for acid-fast bacilli are consistently negative for the final 6 months. Despite the high incidence of patients with preexisting liver disease within the non-cooperative group, adverse liver reactions due to isoniazid, rifampin, and pyrazinamide are remarkably infrequent.

MATTHEW O. LOCKS, MD

REFERENCES

- American Thoracic Society: Guidelines for short-course tuberculosis chemotherapy. *Am Rev Respir Dis* 1980 Mar; 121:611-614
 Dutt AK, Stead WW: Present chemotherapy for tuberculosis. *J Infect Dis* 1982 Nov; 146:698-704
 Locks MO: Tuberculosis, chap 71, In Wehrle PF, Top FH Sr (Eds): Communicable and Infectious Diseases, 9th Ed. St Louis, CV Mosby, 1981, pp 670-730

Exposure of Expectant Mothers to Cytomegalovirus Infections

HUMAN CYTOMEGALOVIRUS (CMV) infections are common worldwide. The epidemiology of this virus has not been completely delineated but it is known that transmission from person to person requires intimate contact. Among adults, the primary route of transmission is by intimate (oral or sexual) contact. Most cytomegalovirus infections are asymptomatic or mild.

Infection with cytomegalovirus has particular significance for pregnant women. The virus can infect the fetus in utero following a primary infection in the mother and, unlike rubella, also by reactivation of latent maternal cytomegalovirus. The risk of manifest congenital disease at birth appears to be largely associated with a mother's first (or primary) infection during pregnancy but the relative contribution to fetal damage by reactivated maternal cytomegalovirus infections has yet to be defined. In the United States 0.5% to 2.2% of all newborns are congenitally infected as shown by viral excretion at birth but most of these infected infants show no clinical signs of impairment at delivery. About 10% of these infections (about 1 per 1,000 births) result in some overt congenital cytomegalovirus disease at birth, but some of the asymptomatic congenital infections may produce effects detectable only later in life.

The results of several studies suggest that from 3% to 28% of all pregnant women in the US shed cytomegalovirus from their cervix by the third trimester of pregnancy. The virus has also been detected in the breast milk of 13% of women with cytomegalovirus antibodies. Such viral shedding is thought to be due predominantly to the reactivation of latent infection during pregnancy. Infants born to mothers shedding this virus may be infected congenitally—that is, during labor or at birth—or postnatally. Most congenital and postnatal infections, like those acquired in utero, are asymptomatic, but some of these infections may conceivably produce subtle effects, the long-term results of which have not been well documented. Studies in the US also indicate that up to 30% of all children acquire cytomegalovirus infections by 3 years of age. Avoiding or reducing the risk of exposure to cytomegalovirus is difficult because of the large number of asymptomatic virus shedders in the general population.

Whether women who provide care to any group of

infants and children have a greater risk of acquiring a primary infection with this virus than women not so employed has not been established. The most important routes of cytomegalovirus transmission from children to adults are apparently via contact with urine or saliva of virus shedders, for example, through kissing or poor personal hygiene after handling soiled diapers. Thus, nursery and other child care staff who are in contact with known infected infants and who adhere to routine patient care practices such as handwashing should not be at increased risk of acquiring a cytomegalovirus infection.

Women of childbearing age should be informed that this virus is ubiquitous and that prevention of infection from infants and children in any setting (home or occupation) is best accomplished by observing good personal hygiene. These women should also be advised that this virus is of relatively low infectivity, and, in contrast to the transmission of rubella and rubeola infection, intimate contact is usually required to transmit it. Antibody testing programs for women who are routinely in close contact with children cannot be recommended at the present time, since there is no information to indicate (or suggest) that such a program would reduce the risk of congenital damage to infants infected with cytomegalovirus. JAMES CHIN, MD

REFERENCES

- Alford CA, Stagno S, Pass RF, et al: Epidemiology of cytomegalovirus. In Nahmias AJ, Dowdle WR, Schinazi RF (Eds): The Human Herpesviruses—An Interdisciplinary Perspective. New York, Elsevier, 1981, pp 159-171
 Exposure of women to cytomegalovirus infections in medical and educational facilities. California Morbidity Supplement No. 7. Berkeley, Calif, State Department of Health Services, Feb 25, 1983
 Stagno S: Isolation precautions for patients with cytomegalovirus infection: An interview with Sergio Stagno. *Pediatr Infect Dis* 1982 May/ Jun; 1:145-147

Office Treatment of Alcoholism

MOST PHYSICIANS have been trained in public hospitals to recognize alcoholism by a patient's end-stage liver disease or other serious sequelae of heavy drinking. Patients who are obviously alcoholic represent only 5% or so of those who will go on to die an average of ten years prematurely because of their alcohol-related problems.

The average alcoholic person is a blue-collar or white-collar worker or a homemaker who drinks too heavily on evenings or weekends or experiences short periods each year when alcohol problems escalate. In these persons, who compose 15% to 20% of the patients seen in practice, cirrhosis rarely develops (seen in only 15% of alcoholic persons), and they are unlikely to enter a physician's office in an intoxicated state. The fall of blood alcohol concentrations to zero on an almost daily basis results in a moderate to mild withdrawal syndrome that, for 95% of these persons, causes tremor, anxiety and a flulike feeling.

Recognition of this average middle-class alcoholic person is important to clinicians because such patients are not likely to respond in a predictable way to therapeutic intervention if they continue drinking. Patients usually have nonspecific complaints, perhaps request a physical examination, and are likely to have mild hy-

pertension (about 140/90), mild elevations in any one or more of a number of laboratory values (uric acid, γ -glutamyl transferase, triglycerides, mean corpuscular volume) or have symptoms of insomnia, impotence or depression. The diagnosis is made by asking a patient (and spouse, if appropriate) about the pattern of life problems and then determining whether alcohol was a contributor. These problem areas include family (a separation or divorce related to alcohol), police (two or more alcohol-related arrests or accidents), job (an alcohol-related loss or layoff) and health (physical evidence that alcohol intake had harmed health, including a history of alcohol withdrawal). Once alcoholism has been identified, confrontation entails reminding patients that they are responsible for their own actions, pointing out ways in which alcohol use has significantly interfered with their life, noting that a long and healthy life will require abstinence and referring them to a treatment program or Alcoholics Anonymous (or both).

The prognosis in alcoholism is good. The chances that a patient will achieve and maintain abstinence for an extended time (longer than a year) increase with the patient's level of stability before entering care. Thus, a person who has an intact family, a job or relevant job skills and an absence of drug problems or non-alcohol-related police difficulties has a 70% chance of being abstinent for one to two years.

MARC A. SCHUCKIT, MD

REFERENCES

- Schuckit MA: Alcoholism and other psychiatric disorders. *Hosp Community Psychiatry*, in press
 Schuckit MA: Drug and Alcohol Abuse—A Clinical Guide to Diagnosis and Treatment. New York, Plenum Publishing, 1979
 Schuckit MA: Treatment of alcoholism in office and outpatient settings, chap 6. In Mendelson JH, Mello NK (Eds): *Diagnosis and Treatment of Alcoholism*. New York, McGraw-Hill, 1979, pp 229-256

Car Passenger Injuries and Child Restraints

THE USE OF appropriate restraining devices (car seats and safety belts) for child car passengers is truly an idea whose time has come. Few health service agencies, such as hospitals, clinics, medical or dental offices, pharmacies or health departments, actively promoted these devices until a short while ago. For children under 15 years, car passenger injuries represent the single leading cause of death in the United States, almost 2,000 fatalities per year.

The younger a child, the more vulnerable he or she is to severe injury or death. Considering the anatomic proportions of children, this finding is not surprising: a relatively higher center of gravity makes a child, when unrestrained, serve as a projectile hurled inside or outside a car when it is stopped by a crash or sudden braking. The "typical" child victim is a 1-year-old who rode unrestrained in the front seat of the family car, and the injury occurred during the daylight hours and in ordinary weather and road conditions.

There is no question that child restraints provide significant protection; unrestrained children are more than ten times as likely to sustain severe injury or

death. Tennessee, the first state to enact mandatory child restraint legislation in 1978, reports a provisional 50% reduction in fatalities. About 30 other states have recently enacted similar legislation mandating car seat or safety belt use by young children.

Through education of their parents, children should be protected against car passenger injuries. Ideally this activity should be initiated during the prenatal period and proceed on through infant restraints to include the use of safety belts by school-age children. This simple, sensible and safe practice will not be easy to implement universally but can be accomplished through a combination of health education, legislation and the development of an increased personal sense of health and safety.

ALBERT CHANG, MD, MPH

REFERENCES

- Accident Facts—1980 Edition. Chicago, National Safety Council, 1980
 Baker SP: Motor vehicle occupant deaths in young children. *Pediatrics* 1979 Dec; 64:860-861
 Centers for Disease Control: State action to prevent motor vehicle deaths and injuries among children and adolescents. *MMWR* 1982 Sep 10; 31:488-490
 Chang A, Levy E: Infant passenger safety education in perinatal services in California (Preventive Medicine). *West J Med* 1982 Aug; 137:162-165
 Scherz RG: Fatal motor vehicle accidents of child passengers from birth through 4 years of age in Washington State. *Pediatrics* 1981 Oct; 68:572-575

Screening for Colorectal Cancer

COLORECTAL CANCER is the second most common type of cancer (excluding skin cancer) in the United States. In 1983 there will be an estimated 126,000 new cases (87,000 colon and 39,000 rectal) with about 58,000 deaths.

The American Cancer Society has issued the following guidelines for colorectal cancer checkups:

- Men and women over 50 years of age should have a test for occult blood in the stool every year;
- men and women over 50 years of age should have annual sigmoidoscopic examinations until two consecutive examinations are normal and thereafter every three to five years, and
- men and women over 40 years of age should have a digital rectal examination yearly.

Persons who are at a high risk of colorectal cancer developing should receive more frequent and intensive examinations beginning at an earlier age. High-risk groups include persons with a history of adenomatous colon polyps or prior colon cancer, Gardner's syndrome, ulcerative colitis, familial polyposis or a family history of colorectal cancer.

The National Cancer Institute's consensus report states that the stool blood test should not be used as yet for screening, until the outcome of ongoing clinical trials shows a decrease in colorectal cancer mortality. The Canadian Cancer Society recommends that the screening use of stool blood test be used only for persons at high risk.

One must realize that most but not all colorectal cancer patients will have occult blood in the stool and that some but not all precancerous colorectal lesions (for example, adenomatous polyps) will bleed; other non-neoplastic conditions may give a positive test for